



County of Los Angeles CHIEF EXECUTIVE OFFICE

713 KENNETH HAHN HALL OF ADMINISTRATION
LOS ANGELES, CALIFORNIA 90012
(213) 974-1101
<http://ceo.lacounty.gov>

WILLIAM T FUJIOKA
Chief Executive Officer

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Third District

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August 31, 2007

To: Supervisor Zev Yaroslavsky, Chairman
Supervisor Gloria Molina
Supervisor Yvonne B. Burke
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

A handwritten signature in black ink, appearing to read "WTF", is written over the printed name of William T. Fujioka.

STATUS REPORT ON MARTIN LUTHER KING, JR.-HARBOR HOSPITAL EMPLOYEE COMPETENCY DOCUMENTATION REVIEW

As reported previously, a Review Team comprised of staff from the Department of Health Services (DHS), the Department of Human Resources (DHR), and my office are conducting a review of documentation on file for employees with clinical assignments at Martin Luther King, Jr.-Harbor Hospital (MLK-H) who may be impacted by the workforce reduction plan. This memorandum provides an update to our August 28, 2007 memorandum.

As indicated in our earlier report, there were 1,596 employees assigned to MLK-H as of August 12, 2007: 918 of these employees have been identified by DHS as being in classifications that may be impacted by the workforce reduction plan; 750 are clinical employees as identified by DHS; and 168 are credentialed and privileged staff. In addition, we reported that the remaining 678 employees are in non-clinical areas.

Credentialed and Privileged Staff (168 employees)

As indicated previously, the competency documentation for the 168 credentialed and privileged employees was not reviewed by the Review Team. DHS has outlined the evaluation process for these employees in the Attachment.

Phase I - Clinical Employees Subject to Potential Mitigation/Workforce Reduction Plan (750 Employees)

The Review Team has completed the review of available employee files to confirm current performance evaluations and other documentation related to competency assessments for the 750 clinical employees that have been identified as being subject to potential mitigation/workforce reduction.

Phase II - Review of the remaining 678 employees at MLK-H

The Review Team has completed its review of the available employee files for the remaining 678 employees in non-clinical areas to document the competencies (based upon classification and assignment, as appropriate) to determine whether current performance evaluations have been completed. A summary of those results will be provided in our next report.

Identifying Employees for Transfer or Reassignment

The results of both review phases are also being used by Chief Executive Office (CEO), DHR and DHS staff to determine which employees will remain at MLK-H and which will be transferred to other locations at DHS facilities or other County Departments.

Members of the Review Team will continue to work over the weekend to make a final determination on the number of employees to transfer or reassign. Based on that review, DHS will draft employee notification letters of transfers assigning them to other facilities. The transfer or reassignment of employees to other vacant positions within DHS and other County departments is prioritized to meet the staffing needs of MLK-H, the expansion programs of Rancho Los Amigos and Harbor-UCLA Medical Center, and then to addressing vacant positions. Consideration of opportunities for transfers to other County departments is being explored for those positions that may not be available within DHS.

Unless otherwise instructed, DHS plans to distribute transfer letters to employees on Tuesday, September 4, 2007. The effective date of those employee transfers will be on Thursday, September 6, 2007 or Friday, September 7, 2007, depending upon the assignments. General and clinical orientation is scheduled for the following week at each of the receiving facilities. The orientation process will include appropriate competency testing for the new location. Competency testing and clinical orientation are planned within 30 days of arrival and before clinical employees provide direct patient care.

Each Supervisor
August 31, 2007
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CEO Employee Relations staff met with Service Employees International Union (SEIU) Local 721 on two occasions to discuss this process.

We will continue to provide your Board with updates, with our next report anticipated by September 12, 2007.

WTF:SRH:SAS
DRJ:bjs

Attachment

c: Executive Officer, Board of Supervisors
 County Counsel
 Director and Chief Medical Officer, Department of Health Services
 Director of Personnel

Status Rpt on MLK_Update No. 3



Health Services
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

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Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Bruce A. Chernof, MD
Director and Chief Medical Officer

John R. Cochran III
Chief Deputy Director

Robert G. Splawn, MD
Senior Medical Director

August 31, 2007

TO: William T Fujioka
Chief Executive Officer

FROM: Bruce A. Chernof, M.D.
Director and Chief Medical Officer

SUBJECT: **MEDICAL STAFF CREDENTIALING AT MLK**

The credentialing/privileging process for new providers requires that each provider provide a completed medical staff application and provide a detailed listing of clinical privileges requested, and complete a moderate sedation & competency exam. In addition the following items are requested and verified: board certification, state license, Drug Enforcement Agency certificate, Basic Life Support/Advanced Life Support Certification, CME activity, three favorable peer references, malpractice claims history, a physical exam, National Practitioner Data Bank report, American Medical Association profile, Medicare sanctions, medical staff/hospital affiliations, and training verifications.

As part of the re-application which all physicians are required every two years to complete a re-application form, moderate sedation & competency exam, submit Board certification status, CME, peer references, malpractice claims, State license validation, Department Chair's evaluation and 10 peer review cases.

The initial and subsequent privileging process is an intensive hierarchical review and verification process that involves the provider's peers, the department chair, the Credentials Committee, the Medical Executive Committee, and subsequently the Governing Body.

In addition to the above, providers at Martin Luther King-Harbor Hospital are part of a new, ongoing and concurrent peer review process implemented approximately five weeks prior to the CMS Survey that continually assesses their quality of care and performance as outlined in the attachment. Cases that do not meet quality indicators are reviewed and appropriate actions are taken. This process entails oversight and coordination from the Senior Medical Director, Dr. Splawn.

During the recent CMS survey, there were no issues identified with respect to the credentialing process including the assessment for competency.

BAC:st

Attachment

c: Robert G. Splawn, M.D.
Sharon F. Grigsby
Antionette Smith Epps

313 N. Figueroa Street, Suite 912
Los Angeles, CA 90012

Tel: (213) 240-8101
Fax: (213) 481-0503

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**LOS ANGELES COUNTY MLK-HARBOR HOSPITAL
RISK MANAGEMENT REPORTING FORM**

CONFIDENTIAL

Attorney-Client Protected Information

Directions: Check the appropriate box and fill in the information section. Immediately give the completed form to QA/Risk Department for processing.

Critical Event (Red Flag): an unexpected serious incident or complication that places the patient or institution at significant risk.

- | | |
|---|---|
| <input type="checkbox"/> Accidental burns | <input type="checkbox"/> Other significant clinical events that may subject the Department of Health Services to adverse publicity or liability |
| <input type="checkbox"/> Admission as a result of an adverse occurrence in the outpatient setting | <input type="checkbox"/> Pathology /tissue mismatch resulting in undiagnosed cancer or delay in Diagnosis of cancer |
| <input type="checkbox"/> Adverse Drug, Contrast, Blood reactions resulting in death or permanent disability | <input type="checkbox"/> Patient suicide (or attempted suicide) |
| <input type="checkbox"/> All birth/brain injuries (e.g. diagnosis of hypoxic-ischemic encephalopathy, seizures in the nursery, apgars < 5 at 5 minutes) | <input type="checkbox"/> Procedures performed by unlicensed staff |
| <input type="checkbox"/> Anticipated death associated with health-care acquired infection | <input type="checkbox"/> Significant equipment related injury |
| <input type="checkbox"/> Adverse outcome after a procedure (e.g. coma, spinal injury, blindness) | <input type="checkbox"/> Significant patient dissatisfaction |
| <input type="checkbox"/> Birth trauma (i.e. erbs palsy) | <input type="checkbox"/> Staff sexual misconduct with patient |
| <input type="checkbox"/> Development of a neurological deficit not present on admission | <input type="checkbox"/> Unanticipated deaths |
| <input type="checkbox"/> Interfacility transfers resulting in disability or death | <input type="checkbox"/> Unanticipated medical and/or surgical complications causing disability |
| <input type="checkbox"/> Intrafacility transfers resulting in disability or death | <input type="checkbox"/> Unanticipated neonatal deaths |
| <input type="checkbox"/> Jail/custody cases (e.g. alleged civil rights violations, alleged discrimination) | <input type="checkbox"/> Unplanned foreign bodies left in patients |
| <input type="checkbox"/> Major disease outbreaks | <input type="checkbox"/> Unplanned nerve damage related to a medical/surgical procedure |
| <input type="checkbox"/> Major loss of function associated with a health-care associated infection | <input type="checkbox"/> Unplanned removal of an organ during surgery |
| <input type="checkbox"/> Maternal deaths | <input type="checkbox"/> Unplanned injury and/or death related to MLK-II hospital care associated infection |
| <input type="checkbox"/> Medical/surgical intervention on the wrong patient | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Mistaken amputations | |

Today's Date: _____	Age/Sex: _____ Male: _____ Female: _____
Patient Name: _____	Admit Date: _____
MRUN: _____	Event Date: _____
Location/Room: _____	Nurse Analyst: _____
Attending: _____	

Describe the critical event. Provide as much information as is currently known, even if only partial report can be given.

<u>QA Office Use Only</u>			
Date Received: _____			
Reviewed by: _____			
<input type="checkbox"/> Reported to _____, M.D., Hospital Risk Manager (x1234)	Date: _____	Time: _____	
<input type="checkbox"/> Reported to _____, RN, Clinical Risk Management (x1234)	Date: _____	Time: _____	
<input type="checkbox"/> Entered in Patient Safety Net (PSN)			
<input type="checkbox"/> Yes	Date: _____	Time: _____	
<input type="checkbox"/> No _____ Already in PSN: ID# _____	Date: _____	Time: _____	
Comments: _____			

Physicians Performance Improvement Committee

Indicators - Department of Ancillary Medicine

Department	Contact Person	QI Nurse Assigned	Volume Indicators	Quality Indicators	Case Review Criteria
Anesthesia.			1. # of consultations (including pain) 2. # of General Anesthetics 3. # of Spinal Anesthetics 4. # of Local Anesthetics	1. Did any of the following occur within 24 hours of anesthesia: ✓ MI ✓ Anesthesia Awareness ✓ Cardiac Arrest ✓ Respiratory Arrest ✓ Re-intubations ✓ Corneal Abrasions ✓ Dental Trauma ✓ Cardiac Arrhythmias requiring intervention Peripheral Nerve Damage Post Dural Headache within 48 hours	1. All intraoperative deaths 2. All post surgical deaths within 24 hours following surgery 3. Cardiac or neuro event within 24 hours following surgery 4. Any airway manipulation or lost airway subsequently requiring an unplanned tracheostomy 5. Intraoperative recall
Pathology			1. Workload (cytology reads, autopsies, etc) per pathologist per month 2. Transfusion service clinical consults/transfusion reaction referrals per month	1. surgical pathology turnaround 2. surgical frozen section turnaround time 3. cytology Non-GYN turnaround time	1. frozen section/permanent section correlation 2. department microscopic peer review 2-3 times per week 3. 10% random peer review of all pathologist's work 4. review of previous cases with current surgical specimens 5. review of all cases at request of faculty and residents
Radiology			1. # of studies read 2. # of radiographic studies performed 3. # of invasive radiographic studies performed	1. blind reads of 1% of all studies read 2. # complications of radiographic procedures 3. #inconsistencies discovered from blind reads 4. Patient deaths related to radiographic interpretation	1. any complication of a radiographic study 2. inconsistencies discovered from blind reads 3. all patient deaths involving radiographic interpretation

Physicians Performance Improvement Committee

Indicators - Surgery

Department	Contact Person	QI Nurse Assigned	Volume Indicators	Quality Indicators	Case Review Criteria
Ophth.			1. # admissions by physician for top 10 DRGs 2. # clinic visits by physician 3. # consultations by attending 4. # operative and invasive procedures 5. # of laser surgeries	1. % post operative wound infections (Outpatient and Inpatient) 2. % cataract extractions with pre-operative visual acuity documented	1. Rare and unique case 2. Unplanned return to OR 3. Unexplained complications
Oral/Surgery			1. # admissions by physician for top 10 DRGs 2. # clinic visits by physician 3. # consultations by attending 4. # operative and invasive procedures 5. # of conscious sedations	1. Dental implants redone within 1 year 2. First dose antibiotics on all facial fractures with 2 hrs. of admission	1. All facial fractures 2. Post operative infections 3. All mandibular nonunions
Oto. (ENT)			1. # admissions by physician 2. # clinic visits by physician 3. # consultations by attending 4. # operative and invasive procedures	1. % tracheostomies performed (elective & emergent cases) 2. # of Trach and to surgery	1. unusual cases 2. unexpected complications 3. deaths
Surgery			1. # admissions by physician for top 10 DRGs 2. # clinic visits by physician 3. # operative and invasive procedures 4. LOS by top 5 DRGs	1. 2. Pre operative antibiotics within 1 hr prior to skin incision 2. Pre operative antibiotics within 1 hour to skin incision:	1. unexpected deaths 2. cardiac or neurological events within 24 hours of surgery 3. unplanned returns to surgery/attending

Physicians Performance Improvement Committee
Indicators - Department of Women's & Children's Health

Department	Contact Person	QI Nurse Assigned	Volume Indicators	Quality Indicators	Case Review Criteria
Obstetrics & Gynecology			1. # admissions by physician for top 10 DRGs 2. # clinic visits by physician 3. # consultations by attending 4. # operative and invasive procedures by physician 5. # of births/deliveries per physician 6. # of low birth weight births	1. 2. Apgar score less than 7 at 1 to 5 minutes 3. Low birth weight less than 2500 grams 4. 3rd and 4th degree lacerations	1. unexpected death 2. missed diagnosis 3. special or unique case 4. complication during invasive procedure 5. Code Purple / Emergent C-sections
Peds			1. # admissions by physician 2. # clinic visits by physician 3. # consultations by attending 4. LOS by DRG by attending	1. Immunizations age appropriate and determined by patient history recorded on their Medical Record 2. Number of revisits by out of control visits by asthma patients	

Physicians Performance Improvement Committee

Indicators - Internal Medicine

Department	Contact Person	QI Nurse Assigned	Volume Indicators	Quality Indicators	Case Review Criteria
Internal Medicine			1. # admissions by physician for top 10 DRGs 2. # clinic visits by physician 3. # consultations by attending 4. LOS by DRG by attending	1. DVT Prophylaxis 2. Stress Ulcer prophylaxis	1. unexpected death 2. missed diagnosis 3. special or unique case